APPENDIX 11

THE CONTROL THERAPY TRAINING MANUAL: DEVELOPING A CLIFF NOTES VERSION

OVERVIEW. This appendix is intended to summarize and illustrate the salient points of CT—a sort of Cliff Notes version of the manual. As noted in the Introduction, the manual is designed for instructors introducing CT as a component of a quarter or semester class, in a workshop, and/or as part of a research/clinical training program. We thought that a "Cliff Notes" version would be helpful as a handout for a class such as Systems of Psychotherapy or as part of a research protocol, where there is only time to present a brief overview of CT.

To that end, we have taken a substantial portion of the entry on Control Therapy from the *Encyclopedia of Psychology* [7] (references are in original) and used it as a "spine" onto which we have added important concepts and elaborations from this manual (italic bold subheadings) and a section on "Control and the Therapeutic Relationship."

We leave it to individual instructors/researcher to customize the material, depending on the goals and objectives of the course or research project (e.g., the appropriate balance between didactic and experiential; specific points that s/he wants to highlight or address more fully). [*] We see CT as an evolving, dynamic therapeutic approach, and therefore we leave the further development of these Cliff Notes (as well as this manual) as a beginning foundation on which others can choose to elaborate and build—thereby helping to further integrate theory, research, and practice for the well-being of clients in particular and the world around us in general.

[*] Of course this needn't be an either/or. Even if only a short time in a class is available to discuss CT, students could still download the entire manual for free, and the instructor could highlight certain pages that s/he wanted them to read as an overview, as well as determine the main points s/he wanted to make about each topic.

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INTRODUCTION: WHAT IS CONTROL THERAPY?

Control Therapy is an integrated approach to psychotherapy and health care that combines theory, research, and practice. Its test construction has been developed and empirically tested through research over three plus decades involving thousands of individuals. Smaller interventional pre post case studies have demonstrated positive effects of Control Therapy with a wide variety of clinical populations, This work has been explored in more than a dozen countries.

Control Therapy rests on the premise that issues of personal control (e.g., desire for control, fear of losing control, power struggles) underlie most concerns brought to therapy; that there are individual differences in people's Control Profiles in terms of their preferred modes for facing this central issue of gaining and maintaining a sense of control; and that for a specific clinical problem, matching clinical control-enhancing interventions to the individual's Control Profile maximizes the opportunity for therapeutic success.

This therapeutic approach incorporates the use of a reliable and valid standardized multidimensional psychological assessment tool, the Shapiro Control Inventory (SCI) to provide a "Control Profile" for the client, showing sense of control in the general domain, in specific life areas, and in regards to motivation for change, desire for change, preferred style for gaining control: i.e., an assertive/change mode of control; a yielding/accepting mode of control; and agency of control (self and/or other).

Control Therapy consists of an 8- to 12-week step-by-step treatment program that involves defining the client's area of concern, performing initial and ongoing assessment, monitoring, goal setting, determining appropriate strategies/skills needed for change, teaching the strategies/skills, and evaluating progress. A Control Therapy Training Manual provides standardized procedures useful for both replicating treatment research and for training clinicians (including an adherence checklist to determine therapist competency and skill development in Control Therapy (Appendix One). Both the SCI and the Control Therapy Training Manual are available online at no charge to licensed health care professionals (www.controlresearch.net).

TOWARD A UNIFYING THEORY OF CONTROL. The theoretical basis of Control Therapy builds upon and integrates several psychological theories and concepts, including Bandura's self-efficacy; Seligman's learned helplessness and optimism; White's concept of competence; Menninger's psychodynamic dyscontrol; Brehm's reactance; Frankl's will to meaning; Adler's will to superiority; Rotter and Wallstons' internal and external locus of control; Schwartz's cybernetic feedback models and disregulation; and Mischel's self-control/delay of gratification. (References for these works and further detailed refinements and nuances of the theoretical foundations and postulates below may be found in Shapiro & Astin [1].

Essentially, control theory rests upon a unifying biopsychosocial foundation and has three postulates: (1) All individuals desire a sense of control in their lives; (2) there are healthy and unhealthy ways by which individuals attempt to gain or regain that sense of control; and (3) there are individual differences in people's Control Profiles; therefore it is important to match clinical control strategies to the person to help individuals maintain a healthy sense of control in their lives.

DEVELOPING A CLIENT CONTROL PROFILE: ASSESSING THE THEORY . A client Control Profile is based on clinical assessment with the SCI, which has undergone extensive reliability and validity testing, including an investigation of neurobiological correlates of control using positron emission tomography. The 187-item, nine-scale SCI is a clinically reliable and valid multidimensional instrument that measures four primary and interrelated components of clients' sense of control: (1) desire for control (i.e., where they want control and why they want it); (2) current sense of control in both general and specific domains; (3) the modes by which clients seek control (assertive/change and yielding/accepting); and (4) use of both self and other agencies in gaining control. Research shows that this method of assessing client Control Profiles is the most sensitive inventory yet devised to differentiate among clinical disorders and between clinical and normative populations.

Control Therapy also includes methods for listening to clients' speech, including client narratives (their "control stories"), control-related beliefs and assumptions, and assaults to their sense of control, and for identifying and monitoring domains where clients feel a lack of control.

Assessment: "Where the client is". A basic premise of Control Therapy is that awareness is a necessary component of the therapeutic process--"knowing where you are". In order for a person to address a problem/concern, the issue has to be brought into awareness and explored. Thus, the first task of Control Therapy is to help individuals recognize what forces are shaping their lives including personal (i.e., behavioral, cognitive, and emotional), interpersonal, and environmental. This is achieved by having the client become familiar with their Control Profile--their overall sense of control, normal modes of control, agency of control, desire for control, domain-specific areas of concern, and assaults to their sense of control.

In the Control Therapy Training Manual, Module 1, four ways which can be used in order to increase awareness of and assess a person's control profile are explored.[*] The first way is through the use of a standardized psychological assessment inventory, the SCI (the Shapiro Control Inventory), to which a majority of this module is devoted. In addition, at the end of this training module, other ways of complementing and deepening our understanding of the Control Profile are also examined, including 2) self-monitoring a control area, 3) listening to and for control speech, and 4) exploring "control stories." (Module 1, pp 17ff).

Different types of awareness. CT acknowledges the importance of different types of awareness: self-awareness that is precise and nuanced (e.g., behavioral self-observation); awareness that is non-evaluative, non-judgmental, and non-clinging (e.g., "mindfulness"); awareness that is present focused in the here and now; awareness that is historically focused (e.g., origins of control stories); and awareness that is future focused (i.e., personal growth and goals) (Module 2, p. 45).

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[*] CT acknowledges the importance of different types of awareness, and discusses other approaches in Module 2, as well as Modules 3.1 and 3.3.

Awareness of control stories and control dynamics. Control stories are formed by the units of control speech, and coalesce and evolve into a narrative—consciously or unconsciously— by which individuals create stories to

- frame, explain, and understand events in our world—why things happen
- seek to explain chaos and disorder—internally and externally
- reflect attitudes and views about the amount of influence we believe we (and others) can and should have over events in our lives.
- Explain our level of motivation and commitment, as well as our ability to develop self-regulation of our thoughts, emotions, and behavior. (Module 1, p 35ff).

Different views of awareness' curative power. Some approaches (e.g., classical Freudian id psychology, Gestalt, mindfulness meditation) posit that awareness in and of itself is curative. Other approaches (e.g., behavioral self-observation) suggest awareness can be curative, but isn't necessarily sufficient. CT believes that occasionally "pure" awareness may be sufficient for healing and "cure". When it isn't, additional tasks are necessary, e.g., goal-setting and interventions. As Confucius wrote, "If you have the wisdom to perceive a truth, but not the manhood (sic)[*] to keep it, you will lose it again, even though you have discovered it." Based on the awareness gained through the assessment phase, the second task of Control Therapy is to evaluate in a more detailed manner the information gained, conduct a self-evaluation, engage in a decision-making process, and set a goal. (Module 2, p. 45).

A CONTROL-BASED VIEW OF PSYCHOLOGICAL HEALTH: SUBOPTIMAL, NORMAL, AND OPTIMAL.

Traditional Western psychology argues that loss of control and learned helplessness are unhealthy and suboptimal. Normal control is defined as gaining control (which even includes an illusion of control) and is equated with mental health. This traditional view argues that instrumental control is good, and that the more control one has, the better even if this means an illusory, over-inflated perception of control or the use of defense mechanisms such as making external attributions for failure.

The theory, research, and practice of Control Therapy agree that "normal" control is better than suboptimal control. However, some normal control strategies (e.g., external attributions for failure, over-inflated sense of control) can also be problematic. They can keep individuals from being aware of the unconscious, reflexive, and reactive nature of many of their control desires and efforts; they are often insular and self-serving; and they can inhibit people from learning from their mistakes.

Therefore, a concept of optimal control is needed. Optimal control, according to Control Therapy, involves the following:

- Increased conscious awareness of one's control dynamics, including

[*] We'd prefer a less sexist term, a gender neutral one, such as the components we discuss in Module 3 as part of the five steps of gaining control: e.g., skill, commitment etc.

affective, cognitive, and somatic experiences, in order to learn when and how desire and efforts for control are expressed; when control beliefs, goals, desires, and strategies are reflexive, limiting, and potentially destructive; and when they should be increased, decreased, or channeled in more constructive directions.

- A balanced and integrated use of assertive/change and yielding/accepting modes of control matched to the situation and goals, desires, and temperament of the individual.
- The ability to gain a sense of control from both self (self-regulation of cognitions, affect, and behavior) and from a benevolent other/Other, (e.g., whether from a doctor or from one's view of the nature of the universe, including religious and spiritual beliefs.

Naïve awareness. We don't have as much control as we believe we do. Our control beliefs and feelings are often naïve, conditioned, and reflexive. We can't really have true free will until we realize how conditioned we are i.e., just how reflexive and automatic many of our actions and desires are. (Concluding remarks, p. 285).

Positive, optimistic self-efficacy ("as if" belief): Beyond naïve awareness. We have the potential to develop more positive control than initially we believe possible. With practice, humans can affect considerable control over many aspects of their lives —both through the assertive mode and the yielding, accepting mode; and can learn to become more aware, take more responsibility for their choices, and increase control over their thoughts, feelings, and behavior in a health-enhancing way (Concluding remarks, p. 285).

One of the principles of Control Therapy is that it is always a skillful strategy and attitude to believe that there is a way to gain a positive sense of control in any circumstance and situation (Module 3.3, p. 197).

We may not be able to develop perfect self-control, but even a little bit more can make a difference. Simply because we are limited in our ability to exert positive control in each mode does not mean that the effort is not worthwhile. If we can only improve two, three, or four degrees, that can make a substantial difference in our lives and the lives of others[*] (Concluding remarks, p. 286).

Therapeutic goal: Addressing symptom "versus" underlying issue*?* Control Therapy does not accept, as the existentialists have suggested, that every health concern is really an underlying fear of death; or that every relationship issue is really a fear of our ultimate existential loneliness.[**] Further, CT does not assume, as do some classical Freudians, that every issue is only a symptom of a deeper problem, and is best seen as an indirect sign to help identify an underlying "cause."

Nevertheless, both these schools of thought contain important insights, which CT incorporates. For example, it can be important to look "beneath" the content area when a) the client has success in one area, but is still dissatisfied; b) the same type of content issue continues to surface, even after the initial one is addressed c) the client rejects all

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[*] Think of the difference a few degrees make in our body temperature: e.g., 98.6 to 102.

[**] Existential root issues (e.g., facing mortality, addressing loneliness, seeking to find meaning) are clearly control-related concerns that all humans face, and try to gain a sense of control about in their own ways. If a client enters therapy wishing to address such root issues, of course they can and should be the focus of the clinical work.

interventions and insists there are no content solutions to the problem (whether change or acceptance), and/or d) the client's affect is out of proportion to the content area being addressed; e) if content issues cannot be successfully addressed as initially conceptualized (Module 3.2 pp. 150-151).

In and through. At the start of Module 1 (p. 9) there is a playful paraphrase of the Socratic injunction: "Know thy… Control profile, control stories, and control dynamics." Control Therapy argues that, in general, and while honoring each client's individual style and readiness, concerns are most skillfully addressed through awareness (i.e., "in") rather than through avoidance, distraction, or denial. Going "through" involves trying to address the concern through change, acceptance, or some combination (see FAQ 13, Module 4, p. 268). To take stress as an example (e.g. Module 3.3, p. 231ff), Control Therapy approaches this concern first through "awareness"-- what is the stressor, what is the client's control profile, the extent to which the client is vulnerable to stress, the client's "usual" focusing strategies All of this is "in." Going "through" involves decisional control, values and beliefs, self and other as agent, setting a goal, and developing appropriate interventions, as needed and useful: a) to address internal feelings of stress b) to address the external stressors c) to cultivate gratefulness and joy. More specifics of goal setting are discussed below (and in Module 2); more information on interventions to create "in and through" are further discussed in the interventions section below, as well as in the manual (Modules 3.1-3.3).

THE GOAL: WHERE THE CLIENT WANTS TO GO. Based on the awareness gained through the assessment phase, the second task of Control Therapy is to evaluate in a more detailed manner the information gained through the first task (assessment and awareness), go through a decision-making process, and set a goal (Module 2, p. 45).

Self-evaluation. The process of self-evaluation may be most effectively undertaken with a certain gentleness and kindness, rather than harsh judgmentalness. During both the self-evaluation and goal- setting phases, the client is invited to o practice a kind-hearted, calm, and curious mindset, and explore his/her own behaviors and attitudes in a compassionate, thoughtful (versus unforgiving, severe, or self-punishing) way…. (Module 2, p. 55)

Decision making process. CT believes that we make better choices by being aware of our decision-making process, and the factors that influence this decision-making. There can be variation in the process each individual utilizes to most successfully choose a goal. Several of these are explored (e.g., amount of choice, information, time desired), so that the client learns about what style works most effectively for him/her (Module 2, 3.3), as well as a person's control dynamics (see Control Mode Dialogue below).

Exploring the two mode goal: Control Mode Dialogue. Whether from a theistic perspective (Neibuhr's prayer) or a non-theistic perspective (Chinese philosophy of dongjing), one task each of us faces in selecting our goals is whether we want to have the goal of being more assertive and making changes; or being more yielding and accepting—toward the situation, our self, and/or others. Although sometimes the goal may seem clear and easy, there are other times when a major task is actually figuring out what our goal is, and then determining the relationship of the modes to that goal. To

facilitate this process, there is an exercise we have developed called the Control Mode Dialogue. (Module 2, p. 67ff) for helping a client explore and understand his/her control dynamics related to the four different modes of control: positive assertive, positive yielding, negative assertive, and negative yielding. Clients are helped to explore their goals—e.g., to alter and change a situation; to learn to accept and be at peace with a situation; or some combination.

Seeking the best goal: As a "mantra," Control Therapy believes the wisest course is to examine our selves, our biases, our goals and, from a centered place, try to arrive at the best goal for the situation, time, place, person, developmental phase, and concern being addressed (cf Module 3.2 p. 179; Module 3.2.4).

Further, the two strategies and goals do not need to be either-or, but can enhance each other. Although there is no comparable concept in Western psychology (or even in English), the Chinese language suggests this possibility of harmonizing change and acceptance modes of self-control through *dongjing:* the proper and balanced combination of the two different modes of control that is right for each situation. (Module 2, p. 63).

CONTROL-BASED INTERVENTIONS.

Therapeutic interventions involve detailed and well-defined clinical instructions for matching treatment strategy to the client's Control Profile, thus offering both standardized, replicable techniques while providing flexibility and sensitivity to each client's individual needs and style.

Based on the goal selected, individually tailored cognitive and behavioral strategies are utilized to help clients re/gain a sense of control through one or both of the positive modes of control. Fostering the assertive/change mode of control, which historically has been emphasized in Western scientific psychology, involves having individuals learn to identify, monitor, and gain active control of those aspects of their lives that are, or should be, amenable to change.

Fostering use of the yielding, accepting mode, which has been historically emphasized in certain non-Western philosophical and spiritual traditions, means helping clients learn the value of surrendering, accepting, and letting go with serenity (i.e., without feelings of helplessness or resignation) of those aspects of their lives that are not under personal control. Yielding can mean letting go of inappropriate or excessive active control efforts. Practical instructions in each mode are explained, as well as ways to integrate and achieve balance between the two positive modes.

Matching client's control profile, goal, and clinical concern to intervention

Interventions in Control Therapy are selected and tailored for each client, based on the Control Profile, the goal, and clinical concern, to help that individual gain a positive sense of control through assertive/change; becoming more accepting, or some combination of the two.

In terms of *modes,* sometimes the intervention chosen will involve the positive assertive mode, sometimes the positive accepting mode of control. Further, sometimes the modes can work in combination: a positive assertive mode can facilitate a positive yielding goal; and a positive yielding mode can facilitate a positive assertive goal.

In terms of *agency*, based on a person's control profile, it is determined the best way to structure the interventions in terms of what proportion optimally comes from self-efforts and/or what proportion from the efforts, support, and guidance of others. (Module 3.1, p. 99)

Learnable skills: CT believes that although there is individual variation, each of us has the ability to

- learn to pause, reflect, consider and reconsider our thoughts, actions, and behavior
- learn to choose to interrupt and override reflexive cognitive, emotional, and behavioral impulses and sequences
- learn to create alternative ways of responding--behaviorally, emotionally, and/or cognitively -- that we feel are more in our (and others') best interest, and which help us gain, or regain a positive sense of control (Module 1, p. 14).

Five steps for the assertive/change mode; the yielding/accepting mode For developing success in each mode, there are five heuristic steps. The process begins when we realize that something is not how we wish it to be in our life—there is a concern or problem (Step One: Desire for control). Step Two is Right and Responsibilltiy. Once a problem is recognized a problem, it is then important to explore whether you feel you have the right to address this concern—is what you're asking for fair and appropriate? In addition, it is critical to assess whether you feel this concern is your responsibility to address (including to what extent it is within your control). This exploration will help you determine your goal: what you want to do about the concern in terms of having a desire for more (or less) control over specific problems in your life. The third step, self-efficacy, is f whether you believe you have the ability to achieve your goal, and how high is your intention to pursue your desired goal. Finally, we get to the actual selection of interventions, Step Four: Skill and Commitment. What are the limits of your skill and ability? Finally, the fifth step, is you define and experience success--what "sense of control" means to you—in each mode. (Module 3.1, p. 101)

Building Blocks. According to Control Theory, each of us is seeking to gain or maintain a positive sense of control in our life. When there is a concern—something seems out of control, we fear losing control, or there is an area where we desire more control—there are two positive modes that can help us achieve that sense of control: either we act assertively to address the issue or we utilize a yielding, accepting mode, or some integration. (Module 3.1, p. 101).

To gain this sense of control, we humans draw from a combination of the fundamental building blocks we humans have at our disposal, what we might call the raw material, the alphabet that can used to construct the skills of an intervention. These building blocks are body, attentional control (where and how you focus attention), decisional control (choices that you make), cognitive and emotional self-regulation (cognitions, images, emotions), behaviors (including speech and actions), other people (guidance, social support, and reinforcement/feedback), and our control stories, including beliefs about the nature of the universe. The Control Therapy approach draws from these building blocks, this alphabet, and puts them together into "words," "phrases," and "sentences" to create an intervention specifically designed for individual's control profile, area of concern, and goal. (Module 3.1, p. 108).

Self and other. CT posits that change can come from others and self as agent; and acceptance can come from others and self as agent. Further, even when an intervention involves "other" as the object of control, we may also need to work on ourselves as additional "objects" (i.e., self-control of our mind, body, emotions) (Mod 3.2, p. 166)

Finding the best response for a given situation: Dongjing. Dongjing is a marvelous word, the equivalent of which does not exist in the English language. It means finding the perfect proportion of yin (yielding) and yang (assertive) action for a given situation. There are three intriguing aspects to this word. First, the word is based on the assumption and belief that if we come from a centered place (i.e., xujing), we can always find the exact right response. That very belief can give a sense of control and self-trust. Secondly, having a word in the language embeds the very idea of looking to integrate the assertive mode and the yielding mode. Finally, the idea of dongjing, the best possible *response* in a given situation, shows how closely *mode intervention* is tied to *mode goal. S*ometimes by laying out different intervention possibilities, we help refine and clarify what our goal is in the situation, as well as the best way to achieve that goal. (Module 3.2, p. 157)

An overview of control therapy principles and practice (Figure 3.2.3 , p. 190, client handout 3.21, Appendix 3). The following figure is a way to summarize the material we have just covered

"Control Therapy in a 'Cliff Notes Form"

1. *Centering Oneself.*

   Take a breath.

   Body Scan-- Ready position physically

   Mind scan/mindfulness

   Gratefulness: Creating a context for the interaction.

2. *Assessment/ Exploration*

   --**Situation/concern.** What is the nature and *content* of the situation of concern? How severe, acute, important?

   --**Other**. If another is involved, what do you know about the other person's interactional style, trust level, and openness to honest feedback?

   -**Self.** What do you know about yourself and your control dynamics, profile, and story that is relevant to the situation?

3. *Goal Setting: Intention***.**

   If everything goes perfectly, what would be the best possible outcome for this situation? i.e., What is your goal for addressing this situation or concern?

4. *Intervention:*

   Creating options for the response (dongjing) that best matches your goal..

   Once you have completed your exploration/assessment, and have your goal, what is the best combination of assertive and yielding modes (dongjing) that you can create to help you achieve your goal?

8 Maximum Yang (most assertive/change)
7 < gradated options
6 for
5 blending
4 and
3 integrating
2 the two modes>
1 Maximum Yin (most yielding and accepting)

Select what you feel is the best option.

Take some time to practice your intervention: e.g., the five steps for the assertive mode; the yielding mode; and/or their integration including the Control Mode Rehearsal as practice.

Implement your choice using right speech and right action. The principle of right speech and right action is to make sure that what you say and how you behave are as clear and fair as possible. This means using speech and action that are no more "yang" than necessary to achieve your goals and intentions, and that seek to minimize hurt and harm to the other person—and to your self.

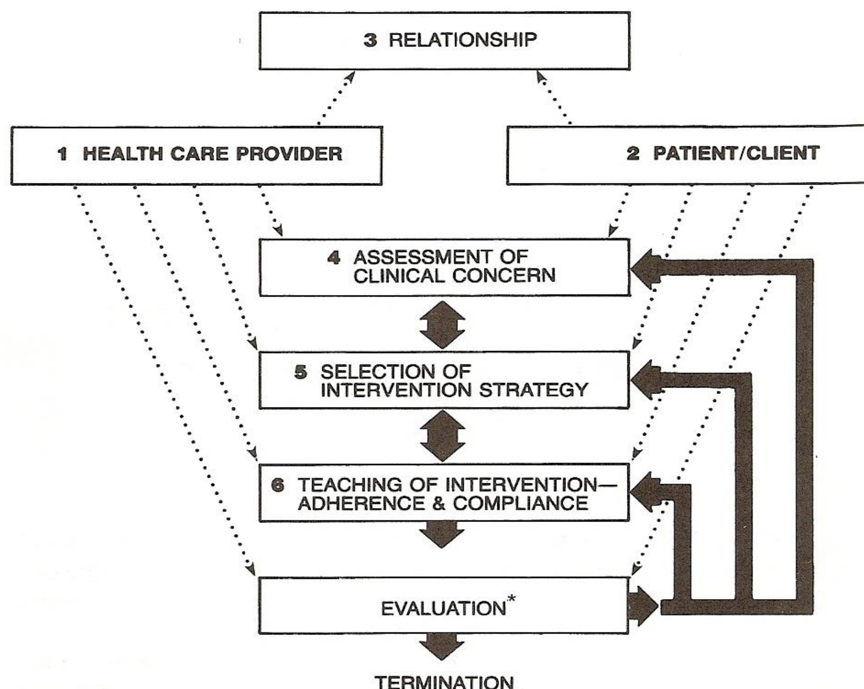
5. Evaluation. Did you achieve your goal? If so, how does that feel to you? If not, what did you learn: e.g., about the other person, yourself, the strategy you used? What changes might you make for next time, or for the next phase of the process.

CONTROL AND THE THERAPEUTIC ENCOUNTER.

Control Therapy is not "taught" in a vacuum, but involves a relationship between client and therapist. The material discussed above (assessment, goal setting, interventions) can only be a template of general principles that need to be refined and adapted depending upon 1) the therapist and his/her orientation, including beliefs about control, about the nature of the therapeutic relationship, and personal style; 2) the client, and his/her control profile, concerns, and goals; and 3) the therapist's and client's assessment of the clinical concern and the range of personal control available in addressing that concern.

A Systems Model of the Components of Control Therapy. As noted in the figure below, there are six components involved in the process of Control Therapy.

A Systems Model of Control Therapy



These include therapist, client, relationship, assessment, intervention selection; intervention "teaching"; and evaluation. As can be seen from the above Figure, components 3-4-5 and 6 are connected by dotted lines signifying that both the client and therapist have views on these components, and these views need to be discussed and articulated to ensure there are no conflicts or misperceptions.

The role of relationship. Each school has a different view of the role of the therapist. This view is based on what constitutes a beneficial therapeutic relationship, on their view of the person, their vision of psychological health, and the barriers that keep individuals from reaching their potential. Classical Freudian id psychology felt the therapist needed to be a detached observer, who would, when appropriate, confront the patient in order to overcome resistances. Client centered approaches, believing the person is innately good, offer non-judgmental warmth and accurate empathy, so the clients can uncover who they already are. As noted, cognitive-behaviorists often see themselves as coaches, teaching new skills. Existentialists highlight the importance of authentic, mutual relationships, viewing clients as fellow travelers on a journey.

In Control Therapy, there may be a place for all of these relational views and skills, at different points in therapy, and depending upon the client. Sometimes we may need to reinforce and honor a client's innate self-worth (Rogerian warmth, empathy, validation); sometimes, teach new skills (cognitive/behavioral coach); at other times, share authentically about the mutual journey (existential); and at still other times, be willing to work skillfully, even assertively, with denial and avoidance. Control Therapy would suggest that none of these positions need be mutually exclusive. (Module 4, p. 258)

The therapist. Just as the client needs to develop awareness of his/her "control style, beliefs, and dynamics" so does the therapist. This includes several topics discussed in the training manual.

Personal awareness*:* The manual discusses the importance of therapist self-knowledge of his/her own control profile, desire for control level, preference for self and/or other agency, preferred modes of control, and control dynamics and stories. ; and interactive style and comfort level. (Module 4, and control stories *(*Module 4, p. 253).

Interactive Awareness: This includes how the therapist handles potential "power struggles" and "control battles" within the therapeutic relationship (transference and counter transference. The therapist's comfort level and style regarding the modes of control; and having a gradated range of skillful responses from positive yielding to positive assertive. (Module 4, p 253ff) .

Views about the efficacy of self-regulation strategies. As a therapist, it is important to be aware of your own views about our human ability to gain a sense of control. For example, as a therapist, what is your theoretical orientation in terms of it's view of human nature and an individual's "natural" ability, personal responsibility and choice to self-regulate thoughts? Feelings? Behavior? To what extent do you as a therapist, believe there are techniques which can help an individual to learn skills to more effectively take responsibility for, make choices about, and regulate their thoughts, feelings, behavior? How much does that view vary across client? Across clinical concern?

If you, the therapist, are personally skilled at using self-control strategies, how do you feel about a client who isn't that effective? How do you deal with your own frustration and feelings of lack of competence at having someone not learn these skills as

quickly as you believe they should? If you aren't able to use self-control that effectively in certain areas of their own life, how do you feel about your efficacy in teaching, and the client's efficacy in learning such strategies? What is your view of the use of medication in relation to self-control? Do you feel it can help a person gain increased control? When might it be appropriate? When not? If there were research showing that either medication or personal control enhancing strategies (if practiced) would work equally well (e.g., in OCD, to address diabetes, heart disease), which would you recommend—for yourself? For your client? (Module 4, pp. 252-253.

Respecting each client's uniqueness. Control Therapy attempts to provide the client an experience grounded in the clients' motivation, encouraging their self-exploration, honoring their unique cultural positions and world view, refining and addressing their self-stated goals, and tailoring interventions to help them meet those goals. In so doing, it helps clients learn how to focus on their own thoughts, behaviors, and feelings within the context of their lives and then learn how to positively influence the world and themselves in healthy and healing ways, whether through positive assertive, positive yielding, or an integration of the two (Module 4, p. 270).

OVERVIEW OF TECHNIQUES WHICH CAN BE UTILIZED IN DIFFERENT PHASES OF CONTROL THERAPY**

Note: references ( ) are to where the material is covered here in the Training Manual--e.g., TM 1 , Appendix 1); and where it is found in the book *Control Therapy:* CT.*)*

ASSESSMENT AND GOAL SETTING: PHASE ONE

Identifying Areas of Concern: Assault to Sense of Control

- Shapiro Control Inventory (SCl): Control profile: Desire, modes, agency (TM 1, App 2, CT Ch. 3)
- Content analysis of language—control speech (TM 1, TM 2, CT Ch. 9, CT App C)
- Self-observation (TM1)

Increasing Awareness: Insight and Outsight

- Control stories: Sources of, exploring (TM 1.4; TM 2.2; TM3.1 CT Ch. 9& 11)
- Control dynamics and assumptions (TM 2, CT Ch. 9)
- Self-observation, self-evaluation (TM 2; Manual homework; CT Ch. 10, 11)^
- Eyes closed mode dialogue: Awareness of preference (TM 2.4; CT Ch. 11) ^
- Six dimensions of control and self-control: (TM2)
- Right and responsibility (TM 3.1; CT Ch. 8, 10, & 11)
- Diaphragmatic breathing (TM 3.1, Appendix 3.11; CT Ch. 10) ^
- Body scan (TM 3, p. 64; Manual Appendix 3.12; CT Ch. 11)^
- Mind scan [In TM3 "attentional control" including mindfulness and big mind game, TM4; and "Appendix 3.10 (mindfulness): mind scan" ; CT Ch. 11)^
- Exploring decision making process (TM 3.3)^

Clarifying Goals

- Control Mode dialogue with resistances (TM 2.3; App 3.8; CT Ch. 11)^
- Envisioning which mode to choose (TM 2.3; CT Ch. 11)
- An external Rorschach vignette (TM 3.2; TM4, 116; CT Ch. 8)
- Breath cycle and the four modes (TM3.1)

** The distinction between intervention phase, and baseline (assessment, goal setting phase) make sense at one level. However, the very act of going to a therapist, assessing oneself, self-monitoring, can also be considered techniques and an intervention of sorts. We realize this even as we sort techniques into two phases in Figure 4.3

Decision making: prioritizing domains & modes. (App 3.9; CT Ch. 11)^
Client handout for short and long-term goals (Appendix 3.2; CT Ch. 12)^
Self-management contract (Manual Appendix 3.7; CT Ch. 11)^
Questions to Facilitate Discussion of Mode Control Stories (App 3.6.; CT Semi-structured Interview, Appendix B),
Eyes closed: Clarifying issues, affect, meaning (TM3. TM4; CT Ch. 11)
Finding the root issue (TM 3.1; TM4, 4 ; Chapter 12, Case 1, p. 240)

INTERVENTIONS: PHASE TWO

Clarifying and Enhancing Motivation

Proactive exploration of barriers to control (TM 3.1; CT Ch. 11)
Enhancing motivation for positive assertive mode (TM 3.1; CT Ch. 11)
Recognizing limits of over control (TM 3; CT Ch. 11)
Enhancing motivation for positive yielding mode (TM 3.1; CT Ch. 11)

Enhancing Self-Efficacy Beliefs and Commitment to Change/accept

Self-efficacy beliefs (TM 3.1; App 3.3 Intention to change/accept CT,Chapter 11) ^
Examining past successes (TM 3.1; CT Ch. 11)
Thoughts to enhance change/acceptance (TM 3.1); CT Ch. 11)^
Reaffirming-commitment to change/acceptance (TM3.1; CT Ch. 11)
Visualizing success in each positive mode Control Mode Rehearsal) TM 3.1

Matching Techniques to Client

Selecting techniques (TM 3.2; TM 4; CT Ch. 8)
Five steps for assertive change mode of control (TM 3.1; CT Ch. 10)
Five steps for the yielding mode of control (TM 3.1; CT Ch. 10)
Dealing with negative thoughts (TM 3.1)
Integrating and balancing two modes (TM 3.2; CT Ch. 10)
Rewriting and editing control-stories (TM3.2.1); CT, Ch. 9)
Control Mode Rehearsal (TM 3.1; App 3.14; CT Ch. 10)
Positive Control Modes in Relationship (TM3.2) ; CT Ch. 13)
Yoga dyad, Tai Chi Dance (TM 3.2)
Xujing (centering) and donging (finding best response) TM 3.2
Concentrative meditation objects of attention (TM 3.3)

Matching Teaching Style to Client

Importance of relationship (TM 4,; CT Ch. 8)
Addressing client's control needs in session (TM 4; CT Ch. 11)
Meeting clients where they are (TM 4; CT Ch. 8 & 11)
When therapist and client disagree: gradated responses (TM 4; CT Ch. 8)
Teaching of techniques (TM 3.2, TM4; CT Ch. 8 & 11)

OVERVIEW: Figure 3.2.3

^= Client handouts and forms in Appendix 3

BENEFITS OF CONTROL THERAPY. Control Therapy has been shown to be effective in the assessment (sensitivity and specificity) of a wide range of mental disorder diagnoses and health-related concerns including Generalized Anxiety Disorder, panic attack, depression, borderline personality, eating disorders, and adult children of alcoholics. Control issues have also been investigated in Type-A individuals with myocardial infarction, women with breast cancer, and individuals at high cardiovascular risk. . Clinical areas investigated through pre

post clinical outcome case studies have shown Control Therapy interventions to be to be effective in reducing symptoms leading to improved clinical outcomes.

There are several advantages to Control Therapy and the unifying theory upon which it is based. First, a unifying theory helps clinicians understand control as a central component underlying all schools of therapy: the analytic view that humans are governed by unknown and uncontrolled forces; the cognitive-behavioral schools' emphasis on self-control; and the humanistic or existential focus on personal choice, individual freedom, and self-determination.

Second, in addition to the theory's universality and parsimony, it also can be operationalized, thereby providing an empirical foundation for assessing a client's Control Profile. Based on individual variations in Control Profiles, specific techniques can be matched to client needs and clinical problem. Drawing from both Eastern and Western psychological traditions, Control Therapy involves specific assertive/change and yielding/accepting modes of control intervention techniques, and the matching of these techniques to a client's Control Profile, goals, and clinical problem.

Finally, Control Therapy articulates a control-based vision of mental, physical, and interpersonal health involving suboptimal, normal, and optimal Control Profiles. Thus, although Control Therapy was designed to specifically address individual mental and physical health problems, it can also be used as a means to help promote growth in many contexts, including intrapersonal, interpersonal, and even societal health and well-being.

FUTURE DIRECTIONS. Further research on the clinical effectiveness of Control Therapy needs to be replicated and extended, and compared to other treatment interventions to demonstrate its effectiveness as a treatment of choice for specific clinical populations.

Control Therapy has been built upon and owes an enormous debt to other approaches. Thus, it is neither a final ultimate panacea, nor a closed system. Therapists from other theoretical orientations may find Control Therapy provides useful insights into how control processes may be relevant to their own therapeutic work with clients. The Control Profile and control stories may help clinicians think about their clients in new, control-based ways. The modes of control may be valuable as a tool for conceptualizing how a sense of control can be achieved (i.e., emphasizing the two positive modes of control). Finally, specific control-based interventions may prove of use as part of the clinical armamentarium.

A FINAL NOTE. As a final note it may be helpful to remember as a context for therapy—and life itself—that we live on a small planet in a small solar system in a small galaxy. On the one hand, we humans are amazingly complex and resilient with vast worlds within each of us. On the other hand, we are also small, fragile, and impermanent physical beings. There is suffering in this world that is part of the life experience, and no amount of control efforts can ever completely ameliorate that. We are all fellow travelers on a temporary journey. This perspective can help us remember that compassion, empathy, and kindness are wise attitudes as a context for our gallant, even noble efforts to teach, learn, and practice positive control in our lives.